ANIMAL EYE CENTER
CLIENT INFORMATION

FIRST & LAST NAME: _____

SPOUSE'S NAME: _____

PHONE #: HOME:_____**WORK#:**_____

CELL#:_____ **SPOUSE'S CELL#**_____

ADDRESS: _____

CITY: _____ **ZIP:** _____

E-Mail: _____

PET'S INFORMATION

PET'S NAME: _____ **SPECIES:**_____

BREED: _____ **COLOR:** _____**SEX:**_____

NEUTERED: _____ **PET'S DATE OF BIRTH:**_____**WEIGHT:** _____

PET'S MEDICAL HISTORY
(CIRCLE HEALTH CONDITIONS THAT APPLY)
SEIZURES THYROID DIABETES SKIN PROBLEMS LIVER KIDNEY
ALLERGIES HEART CONDITION OTHER: _____

PLEASE LIST ALL THE MEDICATIONS YOUR PET IS CURRENTLY TAKING

MEDICATION	HOW OFTEN
_____	_____
_____	_____
_____	_____
_____	_____

NAME OF REFERRING VETERINARIAN: _____
NAME OF VETERINARY HOSPITAL: _____

IS THIS YOUR REGULAR VETERINARIAN: _____**?**

REGULAR VETERINARIAN'S NAME: _____ **NAME OF HOSP:** _____

I AUTHORIZE ANIMAL EYE CENTER TO FAX MY PET'S MEDICAL INFORMATION TO MY PRIMARY VETERINARY HOSPITAL. SIGNATURE: _____

Do you give AEC permission to take photos of your pet and use these images for the purposes of medical records, continuing education, teaching and awareness including educational lecture presentations and social media? _____

DESCRIBE YOUR PET'S PROBLEM: _____

PAYMENT IN FULL IS REQUIRED UPON DISCHARGE OF YOUR PET.

SIGNATURE OF OWNER OR RESPONSIBLE AGENT

X_____ **DATE:**_____